

ADULT CARE HOME COST MODELING REPORT
FACT SHEET
Revised: May 3, 2005

What is the background behind the formation of the Adult Care Home (ACH) Cost Modeling Committee? For several years advocates have complained that residents of ACHs are not receiving appropriate care. At the same time, providers have complained that the reimbursement is not sufficient to cover the actual cost of care. Additionally, the rate setting for the two funding sources for residents in ACHs (State County Special Assistance and Medicaid Personal Care Service) were calculated in two different processes and locations within DHHS. It was time to develop a comprehensive approach to determine the rates and link that closely with resident needs.

What was the mission of the ACH Cost Modeling Committee? The mission was to develop a consistent and defensible costing methodology that considers the full cost of operating Adult Care Home facilities to ensure that resident care needs are met.

What types of homes were included in the study? For purposes of this study, the Committee focused on Homes for Aged Licensed (HALs) facilities of thirty or more beds, with and without a Special Care Unit (SCU) designation, those that were SCU only and eight Mental Health Licensed (MHL) group homes.

Why was the model approach used rather than the existing rate setting based upon cost reports? The Committee was convinced that basing the rate setting on a group of model facilities which met strict standards rather than using the average of all cost reports would drive quality improvements in the industry. This methodology allows for future rate setting that can be updated for inflation, for changes in facility and care standards and that can be periodically adjusted to reflect resident populations and staffing requirements.

What criteria were used for selecting facilities to use in the model? They were:

- An even geographical and urban and rural representation
- A mixture of both private pay and public funding
- Occupancy rate at a minimum of 80%
- Include Special Care Units (SCUs) within facilities and those that are stand-alone facilities
- At least 3 facilities from each of the following size categories: 31-60 beds , 61-90 beds, and 91+ beds
- Facilities must have been in business for a minimum of one year
- No disproportionately high indirect cost ratios compared to direct costs
- No history of penalties and fines
- Once these criteria were met, the facilities were reviewed by industry representatives, the local Departments of Social Services, and the Friends of Residents in Long Term Care as efficient and respected facilities with a good reputation for serving residents

How did the Committee address the resident care needs? All residents in the model facilities were assessed by professionally trained RNs, using the nationally recognized Minimum Data Set instrument, to determine their individual health care needs. The results of the assessments were studied in several ways. Results were compared by a DHHS consultant with significant experience in this field to a national staffing study conducted in nursing homes, to staff needs identified by NC providers, and to regulatory requirements. It was determined that whereas providers are now only reimbursed for 1.1 hours of PCS care, assessments indicate a much higher need—2.31 hours/per/day of PCS for residents of HALs and 4.07 hours/per/day of PCS for residents of Special Care Units.

How does this new approach affect eligibility? The Committee realized that as it reallocated costs from the State County Special Assistance (SA) funding stream to the Medicaid Personal Care Services (PCS) funding stream, there was a negative impact on some residents currently receiving SA payments. After researching several alternatives to avoid this occurrence, the Committee agreed that an income disregard policy was needed.

What is an income disregard policy? As costs are reallocated from SA to PCS, it lowers the financial eligibility amount needed to qualify for SA. Thus, some recipients could have too much income to qualify for SA under the new income standard. An income disregard policy permits the disregard of income up to the amount of the reduction in the SA payment level. This reduction would be used by the recipient to pay for a portion of the PCS services covered by Medicaid. If an income disregard policy is utilized when rate changes occur that do not involve reallocating costs from SA to PCS, that cost is currently estimated to be \$22,660,113.

If the cost modeling recommendations contained in the ACH report are adopted, what will be the new funding requirements? The total cost to fully implement the ACH Cost Model is \$198,834,467.00, of which \$120,167,932 is Federal, \$55,142,385 is State, and \$23,524,150 is county. Please refer to Attachment 6 of the report, Cost to Fully Implement the ACH Cost Model. In addition to the reimbursements, there will be some as yet undetermined systems and administrative costs.

How is improved resident care reflected in these new funding requirements? The greatest portion of the increase in financing to the ACHs is the result of increased hours of staffing required based on the assessments, the adjustments made to the hourly wage rates to achieve higher statewide averages, and an adjustment to provide for benefits to the direct care staff. The Committee believes that these changes are needed to stabilize the workforce, lower the turnover rate, and compensate for the skills needed. These are the same recommendations that have been made by the NC Institute of Medicine in its report on long-term care.

What role will resident assessments play in future decisions about resident placement in long term care facilities? The Committee recommends implementation of an

improved screening and prior approval system and regular assessments of residents to make sure that the services they receive are designed to meet their specific health care needs. The costs of such a program are presented in Attachment 7 of the ACH report. Basically those costs are \$850,000 one time systems development and \$1,344,000 for ongoing operations.

How will the Department guarantee that the increase in rate payments will result in improved quality of care and be expended on the direct care component of provider costs? The report recommends improved monitoring and auditing of the direct care component of cost reports. If increased wages, hours and benefits of the direct care providers are not reflected in the cost report, then the Department may require settlement against that component. The Department is very committed to performance management, and once the funding is approved, an internal group from the Office of the Controller, the Division of Medical Assistance, and the Office of the Internal Auditor will determine specific performance expectations.